

Good Afternoon, I am Dr. Caren Teitelbaum, a senior staff psychiatrist at the Institute of Living, a psychiatric facility here in Hartford. I am a designee of Dr. Linda Durst, the Medical Director at the Institute of Living. I am testifying regarding Bill 131, An Act Concerning the Working Group on Behavioral Health Utilization. I would like to express my appreciation for the Public Health Committee's willingness to hear my testimony. I would also like to express my appreciation to the Insurance Commissioner and the Behavioral Health Task force for their work on mental health parity.

In this context, I am testifying regarding some examples of my and my colleagues' difficulties attempting to care for patients with mental illness at our institution. Of significant concern is that, in our experience, our patients with commercial insurance admitted to inpatient facilities often have tremendous difficulty obtaining appropriate aftercare. The patients admitted to a psychiatric hospital these days are typically much more ill than in the past. They are typically admitted because they are at risk of killing themselves or others or are so profoundly impaired that they cannot function safely in the community. Thus, the imperative for them to have appropriate aftercare can be profound.

For example, many patients are admitted to our hospital because they have a severe dependence on drugs or alcohol and, while under the influence or while withdrawing, they have attempted to commit suicide. When I and my colleagues have recommended a residential 28-day program, which these patients often clearly need, with very rare exceptions, it has been our experience that commercial insurers take the stance that such patients need to "fail" an outpatient program in the community first and the insurers refuse to authorize payment for these residential programs. To my mind, this is the equivalent of saying to a patient on a medical floor, "We know that you have just had a serious medical event and your doctor says you need a skilled nursing facility. However, we will only authorize for you to have physical therapy in the community." This practice is particularly distressing because such patients have already proved by their suicide attempts just how potentially lethal their drug and alcohol problems untreated truly are.

Moreover, we also find that many of our patients just coming out of an inpatient facility are in need of an individual outpatient psychiatrist or nurse practitioner, as well as therapist, and rarely can we find adequate individual mental health providers for our patients that are in their networks.

As another example, I have also learned that my colleagues often have difficulty obtaining authorization for an appropriate level of outpatient care for patients with eating disorders. With regard to anorexia, for example, where patients restrict food, when a patient is very ill and their mental health providers advocate for them to receive a level of outpatient care called a partial hospital program, their experience is often that certain insurers will not authorize this level of care. Patients with such eating disorders not uncommonly starve themselves to the point of severe compromise to their health and even to the point of death. Adequate care can make the difference between health and life on the one hand and severe physical illness and death on the other.

We would be grateful for the passage of a bill which supports efforts by the Working Group to further explore these concerns. The examples I have provided are admittedly anecdotal; however, they do strongly suggest that there is at least a significant question whether mental health parity violations are occurring. We would welcome a bill that would support the Insurance

Commissioner's and Working Group's efforts to gather objective data and believe that this is an important step in the continued effort to ensure that patients with psychiatric illnesses receive adequate and equitable care. Thank you very much for your attention and consideration.